Partnering Effectively With Inpatient Leaders for Improved Emergency Department Throughput

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ABSTRACT
The boarding of patients is a root cause of overcrowding in a majority of emergency departments (EDs) nationwide. It reduces capacity to treat ED patients, decreases bed utilization, and compromises quality, safety, and the patient experience. Because of its systemic nature, it can only be effectively addressed through attention and commitment by all stakeholders. Once emergency departments have addressed throughput challenges they can solve on their own, they are ready to focus on proactive communication and teamwork with inpatient leaders to identify and transfer potential admissions more efficiently. No-delay nurse reports are an important tool to reduce time from admit orders to arrival on patient units. An effective hospital-wide flow committee also removes barriers for admitting patients quickly from the emergency department and addresses a revised January 1, 2014, Joint Commission standard that requires goal setting and measurement to mitigate and better manage the boarding of patients. This article discusses who should attend, the scope of the committee charter, how to use a hospital-wide throughput dashboard to measure results, and includes a sample agenda. It is recommended that the committee also assess and evaluate the effectiveness of the surge plan at least every three years to ensure that it meets goals identified by the committee. This article also shares best practices associated with two key tactics to support an effective hospital-wide throughput committee: inpatient bed huddles to expedite inpatient admissions and inpatient leader rounding, where the inpatient leader rounds on boarded ED patients to ensure safety and quality while also establishing ownership for the transition.

Key words: back-end flow, emergency department throughput, emergency department work flow, hospital throughput committee

SEVERAL STUDIES IDENTIFY that the root cause of crowding in the emergency department is “boarding of patients.” (ACEP Task Force Report on Boarding, 2008) This prolific problem involves “holding” admitted or pending transfer patients in the emergency department, resulting in loss of precious bed capacity. A 2009 white paper (American College of Emergency Physicians, 2009) by the American College of Emergency Physicians noted that 62.5% of emergency departments (and 85% of those with annual visit...
volumes more than 50,000) reported boarding ED patients for more than 2 hours. A 2012 American Hospital Association survey (American Hospital Association, 2010) revealed that 38% of hospital emergency departments were operating “at” or “over” capacity.

Numerous downstream effects result from the boarding burden, including loss of capacity to treat the queue of patients who predictably arrive in the emergency department, longer cycle times for emergency department patients, decreased bed utilization, suboptimal quality and safety for boarded patients, and poor perception of quality and confidentiality by boarded patients housed in hallways (Baker, Shupe, & Smith, 2012).

Although flow models such as split-flow can significantly reduce cycle times and throughput intervals (Baker, Shupe, & Smith, 2013), they do not displace or lessen the gravity of the boarding problem. To improve service and quality in the emergency department, hospitals must confront the institutional, systemic problem of boarding to free the emergency department of the undue burden of caring for inpatients. An essential means to achieving this is through the development of hospital-wide flow teams that engage inpatient unit leaders, physicians, and executives to promote the use of validated real-time systems, principals, and processes.

TIME MATTERS
Efficient disposition is critical for many reasons. ED consumers desire timely care. When ED beds are occupied by patients holding for admission, front-end flow is impacted. Patients then leave without treatment, perhaps the ultimate quality indicator for emergency care. In fact, many patient complaints across the industry are often rooted in excessive wait times to see a provider.

In addition, time-sensitive treatments are dependent on efficient ED throughput. As a result, the Centers for Medicare & Medicaid Services (CMS) now collects and reports throughput metrics, such as NQF 497 (Admit Decision to ED Departure Time), and has already begun to link throughput performance to reimbursement. (Data collection now will impact 2014 reimbursement.)

The current benchmark for best practice is 97 minutes (based upon hospitalcompare.gov benchmarking data between second quarter 2012 to first quarter 2013 ED visits).

The CMS also requires reporting time-sensitive clinical treatments dependent on ED throughput, such as acute myocardial infarction (door to balloon time less than 90 min), acute stroke (time to tissue plasminogen activator less than 3–4 hr), and sepsis: early goal-directed therapy. By connecting improvement efforts to clinical quality to meet best practice standards on these metrics, ED leaders can effectively engage inpatient clinical staff to improve throughput. In addition, physicians and hospitalists are increasingly contractually obligated to meet flow metrics, incentivizing their active partnership in improving throughput in the emergency department.

Facilitating Admissions From the Emergency Department
Best practices for facilitating timely admissions from the emergency department include active identification and communication of potential admissions, the use of no-delay nurse reports, and faxed admission reports. However, before requesting assistance from inpatient leaders on back-end flow, it is critical that the emergency department has first addressed front-end and middle flow—those issues that it can address on its own—to ensure credibility with inpatient leaders.

Identify and Communication Potential Admissions
Once the emergency department has made significant progress with throughput challenges it can impact on its own, it must next focus on proactive communication with inpatient leaders. The ED staff and providers must ensure timely communication to bed management (e.g., patient access, nursing supervisor, director on call) when a decision is made to admit a patient.
It is the emergency department’s responsibility to ensure that information on the status of admitted ED patients is communicated through the appropriate bed management channels and current in the electronic health record or other bed management systems as applicable. To ensure accurate communication and anticipation of admissions, the ED attending physician and charge nurse should round at least every 4 hr at the ED tracking board to review patients’ status, identify need for admission, and assess ED crowding as well as the need to implement a surge protocol, if applicable.

**Utilizing No-Delay Nurse Reports**

No-delay nurse reports reduce time from admit orders to arrival on inpatient units, decrease the potential for handoff errors (because they ensure that both the ED and inpatient nurses have the same information), and increase patients’ perception of care due to timely transfer of care.

A sample process might resemble the following: After the order is written and a request for a bed is made, the ED nurse opens a “transfer of care” report, which is also accessible to the floor nurse. The ED nurse then awaits the patient bed assignment (by monitoring the tracking board). Fifteen minutes after the bed has been assigned, either the unit clerk calls down to the emergency department to accept the patient or the accepting inpatient primary nurse or charge nurse will call to ask questions. In either case, the ED patient is transferred within 15 min of a bed becoming available. No-delay nurse reports are best included in the electronic health record, but a faxed paper report may also be used.

**Best Practices for an Effective Hospital-Wide Throughput Committee**

Beginning January 1, 2014, The Joint Commission (TJC) revised standards LD.04.03.11 and PC.01.01.01 (The Joint Commission, 2012; which govern patient flow through the emergency department) to include a requirement for goal setting and measurement to mitigate and better manage the boarding of patients. This includes a requirement for individuals to manage patient flow processes to review measurement results to goals and take action to improve patient flow when goals are not achieved.

An effective hospital-wide throughput committee addresses this need by meeting monthly and typically convening 12–15 individuals who can best drive process improvement and remove barriers for admitting patients quickly from the emergency department. It is an interdisciplinary team that typically includes hospitalists, leaders from the emergency department (e.g., director, manager, flow coordinator), and inpatient leaders from critical care, telemetry, and med-surg.

“Although we may consider the operational components from the emergency department to inpatient to be a care transition, we must evolve our processes and mindset to one of a team approach to support a patient-centered continuum of care,” notes Dan Smith, MD, FACEP, one of StuderGroup’s medical directors and an expert on ED flow efficiency.

This group may include the environmental services leader, transport leader, admissions leader, administrative supervisor (nursing supervisor), risk manager, and discharge planner/case manager. Attendance by a senior leader sponsor is also important for buy-in and accountability.

The charter of the hospital throughput committee should clearly define its scope and focus. The scope and focus of this committee should promote the creation and monitoring of measurable outcomes that address the above mandates from CMS and TJC. The committee members must not lose sight of the importance to address back-end ED flow as a hospital-wide problem that only this type of interdisciplinary team can correct. The meeting agenda flows from these goals with a review of “wins,” priority throughput indicators, clinical quality issues, financial impact from reducing length of stay, and review of the hospital’s current “throughput dashboard.” The purpose of this hospital-wide throughput dashboard is to collect and track
current data on key metrics so that the team can identify trends and performance gaps, and when centered around it, teams can ensure that meetings are productive and actionable.

Dashboard data typically include measures such as disposition to admission by unit, disposition to admission by time of day, hospital discharge by time of day, staffing by hour (for ED nursing, environmental services, and hospitalists), and other inpatient admission process times. Process times may include total turnaround time for admitted patients, time of physician order to discharge to patient departure, patient departure to notification of housekeeping, notification of housekeeping to bed clean, bed clean to assignment of new patient to bed, and time of bed assignment to new patient in bed.

The team can also track bed assignment time to report received to ensure that no-delay nurse reports are occurring consistently. To ensure compliance with and tracking of NQF measures as required by CMS, the dashboard should include these metrics as well. Other optional metrics for this dashboard may include environmental service turnaround times, post anesthesia care unit (PACU) hold hours, and ED hold hours/diversion hours (see Figure 1).

As each leader reports out on next action steps with dates due, these are captured in the meeting minutes for follow-up. Goals to consider include times for inpatient to discharge, room assigned to occupied, discharge order goals, environmental service turnaround times, PACU hold hours, and ED hold hours.

It is recommended that this committee also assess and evaluate the effectiveness of the surge plan at least every 3 years to ensure that it is producing desired results on the basis of

Figure 1. Sample dashboard of performance metrics for hospital-wide throughput committee. A full-size copy may be downloaded at www.studergroup.com/samplethroughputdashboard.
the charter and goals identified by this team. A strong and effective surge plan identifies specific actions for ED, inpatient, administrative, and ancillary leaders through a tiered response. Each of these tiered responses should have specific action items within them for all departments that impact transition of patients out of the ED. Each of these responses should be precisely designed steps to prevent escalation to the next level.

By collaborating closely with inpatient units, the emergency department at UConn Health, an integrated academic medical center in Farmington, Connecticut, has made dramatic gains in ED throughput in just 2 yr. Over 24 months, the team has reduced ED arrival to departure time from 461 to 336 min and ED admit decision to departure time for admitted patients from 225 min to 143 min.

“Having physicians write transition orders has also really reduced bottlenecks. In fact, we’ve reduced the time from admit decision to transition orders from 102 minutes to 22 minutes in just the last six months by coordinating this process closely through the ED physician, hospitalist and an inpatient resident,” explains AnnMarie Capo, associate vice president for clinical effectiveness and patient safety. “Instead of having one medical officer of the day visit patients in the emergency department, transition orders move patients to the inpatient unit quickly where inpatient nurses can more efficiently divide the work and expedite quality patient care.” Moving a case manager into the emergency department full-time has also ensured that all stakeholders are together to assign bed placements.

**Tactics to Support an Effective Hospital-Wide Throughput Committee**

**Inpatient Bed Huddles**

These must occur at least daily and they must be actionable to achieve goals the hospital-wide flow committee has set. Each unit should be represented in the bed huddle and leave with individual action items to discharge patients, prevent delays, and address surges. Expedited admissions to inpatient units and the timely transition of patients to admission should be everyone’s priority as it produces the best possible outcome for patients.

During huddles, best practices such as early inpatient discharge (before noon), unit discharge rounds, a “pull until full” philosophy with “zero tolerance” for hiding beds, and elimination of unit-specific bed control should be monitored and reinforced. High-performing organizations utilize an afternoon bed huddle to follow up on action items identified earlier in the day and the results they have generated or the need to escalate to others. During times of surge, these same organizations move their inpatient bed huddles to the ED to generate urgency in patient transition and to facilitate inpatient leader rounding.

**Inpatient Leader Rounding**

Inpatient leader rounding, in which the inpatient leader rounds on boarded ED patients, is another key tactic to support the actions of the hospital-wide flow committee. Before implementing inpatient leader rounding, ED leaders must generate engagement by sharing the “why,”—the benefits for inpatient leaders to rounding with their patients, before emphasizing the “what” and “how.”

Inpatient leader rounding ensures both safety (e.g., a safe handoff and safe acceptance of inpatients) and quality (e.g., improved morbidity and mortality). By connecting inpatient leaders with patients holding in the emergency department, we also establish ownership for the transition, building trust. (Staff rounding on patients reduces anxiety around unexplained and uncertain waits for better clinical outcomes; Meade, Kennedy, & Kaplan, 2010.) Frequency of inpatient leader rounding on ED patients is tied to the hospital surge plan with clear guidance and instruction for inpatient units and defined roles and expectations for staff and physicians at tiered surge levels. Inpatient leader rounding is driven by the chief nursing executive or other senior leader sponsor.

The inpatient nurse manager or charge nurse rounds on ED patients awaiting admis-
sion in the emergency department. By role modeling rounding, patients are introduced to the rounding process they will experience on the inpatient unit. In starting this practice, it is recommended to begin on one or two pilot units to conduct a test of change using the institution’s change management philosophy (e.g., plan-do-study-act).

When inpatient leaders round, the goal is to use good listening skills (e.g., refrain from interrupting or rushing the patient), repeat back concerns to ensure that the patient was heard, express a genuine apology where appropriate, thank the patient for entrusting the hospital with his care, express empathy, and explain specifically what the leader will do to address a concern without blaming others or offering excuses.

The inpatient leader should leave a business card and write his or her name and contact information on the ED communication/care board. In addition, the unit phone number is provided to family and visitors. To ensure both effective collaboration and a positive patient experience, the inpatient leader must never “manage down” the admissions process. Rather, it is imperative to reinforce the excellent care patients are currently receiving in the emergency department and share positive steps occurring in process for the transition to inpatient care.

There are many direct benefits to inpatient leaders who round on patients in the emergency department. They ensure that the patient is appropriate for the unit and nursing assignment as well as proactively addressing special needs before transitioning to the inpatient unit. In this way, the inpatient unit can exceed patient’s expectations with respect to pain, cultural issues, and spiritual care. In short, inpatient leader rounding on ED patients improves patients’ perception of care, which is reflected on patients’ ratings on the Hospital Consumer Assessment of Healthcare Providers and Systems survey.

CONCLUSION

Over the years, emergency departments have tried many tools and tactics to improve back-end flow. These range from expanding the emergency department by building more rooms; using special discharge or observation units when at full capacity; utilizing ED nurses as inpatient nurses with boarded patients; ambulance diversions; and in the emergency department. However, boarding is not an ED problem. It requires effective, consistent hospital-wide collaboration to facilitate timely admission to inpatient units as well as ongoing monitoring, measurement, and real-time process improvement by a hospital-wide throughput committee.

When ED leaders focus their efforts on partnership and collaboration rather than isolation and finger-pointing, many barriers to resolve the issues before them can quickly erode. As difficult as it can sometimes be, challenging ourselves to elevate above the potential for conflict and reach across boundaries to the inpatient world will deliver the best results for our patients. To accomplish this and to gain and maintain credibility with our inpatient colleagues, we must ensure that we have first addressed internal ED flow issues to the best of our abilities. This will generate evidence of our own ability to change, improve care quality, and generate results that impact all patients. With this type of “you go first” change leadership, anything is possible!

REFERENCES


